



OFFICE OF THE COMPTROLLER COMMONWEALTH OF MASSACHUSETTS

Request for Setting Up Capital Programs

TO:Capital Accounting

Date: _____

Office of the Comptroller
One Ashburton Place, 9th Floor
Boston, Massachusetts 02108
Attention: Maggie Trudel

Fax: 617-727-2163

Capital Program Request

Fiscal Year _____

Department _____

Major Program Table

Please list the Major Program this program is reported under.

Major Program (**6 chars. or less**) _____
Major Program Name _____
Short Name (max 15 char) _____
Major Program Category _____

Program PeriodTable Set-Up

OSC recommends using Program Period= EPP - Extended Program Period

Department	_____		
Major Program	_____	Effective From	Effective To*
Program Period	_____	_____	_____
Program Period Name	_____		
Short Name (15 chars. o r less)	_____		

Program Table Set-Up

Program Class	_____		
Department	_____	Effective From	Effective To*
Program Code (10 char. or less)	_____	_____	_____
Program Name	_____		
Program Short Name	_____		
Program Description	_____		



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*If end dates coincide with the last day of a fiscal year (i.e. 6/30), the end dates should extend through the AP Period to capture late payments. E.G. An end date of 6/30/xxxx should be changed to 9/30/xxxx.

OPTIONAL FIELDS:

Phase

Department

Phase (6 char. or less)

Phase Name

Phase Short Name

Program Phase

Department

Phase

Program

Activity

Fiscal Year

Department

Activity (4 char. or less)

Activity Name

Activity Short Name

Comments:

SIGNATURE:

Department Head or Authorize Signatory